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RHODE ISLAND DEPARTMENT OF HEALTH
H1N1 VACCINE ADMINISTRATION RECORD & CONSENT

☐ **INTRANASAL**

☐ **INJECTABLE**

☐ 6-23 mos.	☐ 24-59 mos.	☐ 5-18 yrs.	☐ 19-24 yrs.	☐ 25-49 yrs.	☐ 50-64 yrs.	☐ 65+ yrs.

I. PATIENT INFORMATION

Name: (Last) (First) (M.I.)		Date of Birth _____/_____/_____
Address:	City: St. Zip	Sex: __ Male __ Female
Telephone:	Emergency Contact/Guardian Name:	
Emergency Contact/Guardian's Phone Number:	Relationship to Patient:	

Primary Care Physician: _____ Practice Name: _____

Address: _____ Phone: _____

II. INSURANCE INFORMATION (Your insurance company may not be charged an administration fee)

VACCINE IS FREE OF CHARGE

III. MEDICAL SELF-ASSESSMENT/SCREENING

Please complete self-assessment on reverse side of form.

Both you and a clinical staff member will review this document prior to receiving the vaccine.

IV. H1N1 VACCINE ADMINISTRATION CONSENT

I have read or have had explained to me the information provided in the Vaccine Information Statement (VIS) about H1N1 influenza and the H1N1 influenza vaccine. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of H1N1 influenza vaccine and request that the vaccine be given to me or to the person named above for whom I am authorized to sign.

I certify that I have received and/or reviewed a Vaccine Information Statement (VIS)

SIGNATURE: X_____DATE: _____

V. VACCINE SELECTION (To Be Completed by Clinical Staff Only)

Hospital:	**MR #:**
Manufacturer:	**Account #:**
Lot Number: _____ Expiration Date: _____/_____/_____	**VIS Date:** ☐ **10/02/09 H1N1 LAIV** ☐ **10/2/09 H1N1 Inactivated**

_____ **Name of Vaccine Administrator** _____ **Signature of Vaccine Administrator** _____/_____/_____ **Date (MM/DD/YY)**	**Administration site:** Intranasal L R; Deltoid L R; Thigh L R	**ADMIN FEE CHARGED?** ☐ **YES** ☐ **NO**

Self-Assessment/Screening for H1N1 Vaccination

Please complete the questions below to help us determine whether you should receive the intranasal or injectable form of the H1N1 vaccine. If you answer yes to any question, it does not mean that you should not be vaccinated; it only means that additional questions must be asked. If a question is unclear, please ask your healthcare provider to explain it.

	Yes	No	Unknown
1. Is the person to be vaccinated sick today?			
2. Has the person to be vaccinated ever had a severe allergy to a component of the influenza Vaccine (eggs, thimerosal, formaldehyde, gelatin, neomycin)?			
3. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past?			
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?			
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?			
6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?			
7. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?			
8. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?			
9. Is the person to be vaccinated pregnant or could she become pregnant within the next month?			
10. Is the person to be vaccinated younger than age 2 years or older than age 49 years?			
11. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective isolation (such as in a hospital room with reverse air flow)?			
12. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?			

Form completed by: Date:

Form reviewed by: Date:

Adapted from Immunization Action Coalition Literature